

# ADDICTION AS DISABILITY: INCLUSION WITHIN LEGISLATION

Jake O'Flaherty

## THE POST [ | ] VOLUME 2 NUMBER 1

LAKEHEAD UNIVERSITY'S INTERDISCIPLINARY UNDERGRADUATE RESEARCH JOURNAL

---

**Abstract:** Contemporary disability legislation often includes addiction in the category of disability. The choice to exclude addiction from this legislation can create unnecessary barriers for those people with addictions. Exclusion of addiction from legislation may block an affected individual from being able to access benefits or services which could potentially help them succeed. This paper applies Schneider and Ingram's (1993) model of social construction to an understanding of the issues surrounding the inclusion of addictions in disability legislation. With inclusion of addictions in disability legislation, people with addictions are viewed in a more positive light, both by themselves and by society at large. This more positive construction would both identify and assist in engineering a shift in societal perceptions. As well, inclusion potentially increases access for affected persons to benefits and services. Increased access would likely help to destigmatize addiction and therefore meaningfully support people who seek overcome them. Logistical complexities inevitably arise in considering the creation of an accessible society for people with addictions or substance issues, but contemporary studies suggest that inclusion in legislation would have effects that are more positive than negative.

**Keywords:** Inclusion, Social Construction, Substance Use, Disability Benefits, Assistance, Lawmaking, Legal Policy

---

**Jake O'Flaherty** wrote this paper while in the third year of Lakehead University's Honours Bachelor of Outdoor Recreation, Parks and Tourism program. At the time of publication, he is finishing his Honours Thesis study, which focusses on assessment and classification of multi-use trails in the Lake Superior Marine Conservation Area.

When the term "disability" is used, what often gets pictured are people with physical or intellectual challenges rather than people with substance abuse issues. Consider that some 40.3 million people in the United States alone are living with addictions (Goodwin & Sias, 2014). Addictions and substance abuse disorders are viewed in a more negative light than more "traditional" disabilities. As a result, people affected by addiction often have a more difficult time accessing services or accommodations related to their condition (Brucker, 2009).

This paper discusses the implications and potential outcomes of the inclusion of addictions in disability legislation from a social model perspective. Addictions are a part of the Accessibility for Ontarians with Disabilities Act of 2005 (Government of Ontario, 2005). Although they are included in Ontario's 2005 Act, it should be noted that the Americans with Disabilities Act in the United States and the Equality Act in the United Kingdom do not fully recognize addiction or substance abuse disorder as a disability (Brucker, 2009; Flacks, 2012). Their lack of inclusion in legislation leads to stigmatization and creates a barrier for people with substance abuse disorders, inhibiting them from becoming fully contributing members of society.

The implications regarding addiction and substance dependency, and their inclusion within or exclusion from legislation as manifestations of disability are complex. These issues can be viewed through the social construction model (Brucker, 2009; Flacks, 2012; Schneider & Ingram, 1993). Using a system of classifications, this model can help to explain why there is variance in societal perception between those with addictions and those with more "traditional" disabilities. The social construction model is also particularly useful in better understanding the social model of disabilities (Brucker, 2009; Oliver, 2013; Schneider & Ingram, 1993).

Schneider and Ingram's (1993) social construction model suggests that with a shift in perception and deconstruction of the current stigma surrounding addiction, additional programs and services can be made more readily available (Brucker, 2009; Flacks, 2012; Goodwin & Sias, 2014). Arguments against this inclusion as well as those critiquing the use of the social model of disability have been presented, but

the case for its use and for addictions inclusion in legislation seems to be more resolute in recent literature. It is clear and significant that scholars repeatedly call for a societal overhaul and the continued fight against the stigma of addiction.

### **Literature Review**

Even with a legal acknowledgement of addiction as a disability, the segment of the population suffering from (or affected by) addiction remains severely under-represented in terms of funding, support and availability of treatment programs. The National Centre on Addiction and Substance at Columbia University (2012) found that in the United States, \$43.8 billion dollars are spent on treatment for the 25.8 million people affected by diabetes, while just \$28 billion is spent on treatment for the 40.3 million people affected by addiction (Goodwin & Sias, 2014). Societal perceptions that people with addictions are not deserving of assistance or of funding further hinders the chances affected individuals may have of receiving such assistance (Brucker, 2009; Flacks, 2012).

The Accessibility for Ontarians with Disabilities Act (2005) categorizes addiction as a disability. This means that individuals with addictions are to be accommodated in the workplace to a reasonable degree (Government of Ontario, 2005). Under the classification of disabilities, people with addictions are protected from discrimination and given opportunities to join the workforce, and are more likely to become functioning members of society (Brucker, 2009). In contrast, the United Kingdom's Equality Act leaves out addiction and substance abuse. Simon Flacks warns that the decision has rather serious ramifications (Flacks, 2012). These include continuing stigmatization of problem drug users, which in turn creates a barrier for those individuals to joining the workforce. Continued stigmatization and the barriers that result from it together create a culture of exclusion in which those individuals most in need of help are dehumanized.

In 1996 in Australia, a man undergoing methadone treatment was expelled from a social club because of reports of his alleged intoxication (Wayne Marsden v Coffs Harbour and District Ex-Servicemen & Women's Memorial Club Ltd., 1999). He filed a complaint with Australia's Human Rights and Equal Opportunity Commission, suggesting that the board members of the club had discriminated against him, that

his addiction was a disability, and therefore they were in violation of Australia's 1992 Disability Discrimination act. Ultimately, the case was settled out of court, but as a result of the incident new legislation was put forward. An exclusion clause to both Australia's Federal and State legislation was added regarding the place of addiction within the realm of disability (Seear & Fraser, 2014). This exclusion was in response to a significant public outcry, and was intended to prevent people with addictions from accessing disability benefits.

In this case, it should be noted that the Australian Human Rights and Equal Opportunity Commission (1999) ruled that the plaintiff did not meet the definition of someone who has a disability (Wayne Marsden v Coffs Harbour and District Ex-Servicemen & Women's Memorial Club Ltd, 1999). Simon Flacks (2012) informs that the United Nations' criteria for disability is:

... loss or limitation of opportunities to take part in the life of the community on an equal level with others due to physical, social, attitudinal and cultural barriers encountered by persons having physical, sensory, psychological, developmental, learning, neurological or other impairments (including the presence in the body of an organism or agent causing malfunction or disease). (2012)

Flacks argues that addiction fully fits into this criteria, and Goodwin & Sias (2014) extend this line of reasoning a step further. They argue that addiction should be viewed as a chronic condition in addition to a disability, on the grounds that it shares characteristics with ailments such as diabetes, hypertension and asthma. These (including addiction) are all conditions which result in the necessity for the individual to be closely monitoring their lifestyle. Each of these conditions also requires treatment. Deborah L. Brucker's (2009) analysis of the disability policies of Australia, Canada, Germany, Japan, the Netherlands, South Africa, Sweden, the United Kingdom and the United States notes that addiction *can* fit within all of their national policies as a disability, although in some instances that is not borne out by legislation. The key finding of Brucker's analysis is that the policies which these countries enact reflect social norms regarding substance use, which in turn affects how their citizens understand addiction in the context of disability (Brucker, 2009).

## **Social Models: Social Construction Model**

Exclusion of addictions from disability legislation prevents people with addictions from claiming disability benefits. Exclusion commonly results from a societal assumption. This assumption holds that affected individuals have made a choice to become addicted, therefore they are not worthy of assistance (Brucker, 2009). Schneider & Ingram's (1993) model of social construction has been used to attempt to explain this occurrence. This model breaks down populations into four categories: advantaged, contenders, dependents, and deviants. Within this model, people with "typical" disabilities are viewed as weak but are positively constructed. These people fall into the "dependent" category, and society feels a moral obligation to assist them. Those with addictions are also considered weak, but this weakness is negatively constructed, placing them into the "deviant" category (Brucker, 2009; Flacks, 2012; Schneider & Ingram, 1993). Deviants are then excluded from policy and social assistance, unlike dependants (Schneider & Ingram, 1993). A key difference between deviants and dependants is the way policy is typically directed towards them. In the social construction model, deviants are typically targets of policies involving punishment, as they are perceived to be deserving of such. Dependants, however, are less unattractive in the public eye and tend to have policies tailored toward providing for their assistance. Dependants are deemed to be in need of (and deserving of) care. Including people with addictions in the disability category moves them closer to the dependant designation, where they might receive substantially more assistance and treatment (Goodwin & Sias, 2014).

## **Social Models: Social Model of Disability**

Viewing addiction as a crime hinders the chances of an individual with an addiction from contributing positively to society (Flacks, 2012; Brucker, 2009; Wasserman, 2004). Many academics instead call for approaching addiction as a health issue rather than one requiring punishment. If addiction is considered a disability, then both medical and social models should be used to examine barriers that people with addictions face (Wasserman, 2004). It is beyond the scope of this paper to apply

both the medical and social models of addiction in their entirety, so only the social model will be explored here.

Originally conceived in the 1980s, the social model is rooted in the idea that disability is not a result of impairment, but instead is a product of societal barriers (Oliver, 2013; Owens, 2015; Wasserman, 2004). This model has been successfully utilized by disability rights groups to make the world more accessible for people with any sort of disability (Oliver, 2013).

Applying the social model of disability to addiction suggests that society needs to reform, and ought to rethink the current constructs in place disabling people with addictions (Flacks, 2012; Wasserman, 2004). One of the largest barriers preventing people with addictions from succeeding is society's stigmatization of them, articulated by culture and reflected in policy (Goodwin & Sias, 2014). If we are to create a truly inclusive society, then this stigmatization must end. It is our moral obligation to serve these people. We must do what we can to remove barriers and make aspects of our society more accessible (Flacks, 2012; Brucker, 2009).

Stigmatization of people living with addictions and substance dependencies hinders the availability of adequate care, care that a person living with another disability (or disabilities) may be able to more easily access (Goodwin & Sias, 2014). Often, treatments are offered for symptoms of addiction but rarely can the root problem be addressed. This is sometimes because factors causing dependencies are unique to each individual, as are coping methods and intensity of substance use (Goodwin & Sias, 2014). Reports also inform that individuals must follow strict guidelines and go through extensive processes to even begin to receive assistance with their addictions (Brucker, 2009; Goodwin & Sias, 2014).

## Discussion

Following the social construction framework set out by Schneider & Ingram (1993), the creation of a culture of acceptance for those with addictions will result in a shift of their categorization from deviants to dependants (Brucker, 2009). This can be facilitated in part by the inclusion of people with addictions into disability legislation (Flacks, 2012). Inclusion into legislation such as the Accessibility for

Ontarians with Disabilities Act ensures that the individuals will be accommodated for in daily life within reason (Government of Ontario, 2005).

The social model itself has been criticized as being one which leads to a hierarchy of sorts in terms of impairments, often at the expense of those which are not clearly noticeable, such as addictions or mental health issues (Owens, 2015). This oversight or erasure is addressed by proponents of the social model, who suggest that the hierarchy is a by-product of misuse of the model, not the model itself (Oliver, 2013). Another key criticism is that the connection between personal impairments relating to social barriers is not acknowledged (Owens, 2015; Samaha, 2007); this is countered by the notion that any connection is irrelevant as long as the barriers are addressed and accommodated for (Oliver, 2013).

David Wasserman (2004) warns that a true rendition of the social model accommodating those with addictions would be grossly impractical and would require a complete social, cultural and physical overhaul of our environment. As impractical as that may be, Flacks (2012) urges that it is society's responsibility to reduce the barriers when possible. Flacks' suggestion applies especially to the stigmatization of addiction, even if a utopian world cannot be achieved. Flacks writes: "reconceiving addiction as a mental health problem rather than a moral failure would ... be a first step" (p. 402). One possible result of the inclusion of addictions in disability legislation is that addictions would be looked upon in a less negative light than they currently are. This could, in turn, open up the potential for access to services and accommodations for people with addictions to improve their quality of life (Brucker, 2009; Flacks, 2012; Goodwin & Sias, 2014).

For those living with addiction, the road to inclusion is not a smooth one. Being recognized as disabled rather than deviant would certainly benefit affected persons (Flacks, 2012; Government of Ontario, 2005; Schneider & Ingram, 1993). However, the goal of inclusion cannot be fulfilled simply by making an amendment to policy. For those people living with addictions, overcoming the underlying barriers to becoming contributing members of society might begin with the important work of reversing the social stigma associated with drug addiction. This stigma is primarily caused by the view that a person with an addiction is a social deviant (Brucker,

2009; Schneider & Ingram, 1993). The social stigma acts as a barrier, disabling individuals by blocking their access to assistance and to helpful services (Goodwin & Sias, 2014). There is no easy solution to this issue, and clearly, it is not a change that can occur instantly (Wasserman, 2004). Policy amendments regarding the inclusion of addictions in disability legislation will begin to break down the barriers imposed by the existing legal framework, which in turn can help remove the stigma in public perception.

The main purpose of this paper is to investigate the implications of having addictions framed within disability legislation from a social model perspective. It can be inferred that current legislation is reflective of a larger societal perception of addiction and people affected by it. If categorically included within disability legislation, individuals with addictions will have better access to services and more easily gain treatment or assistance. This inclusion can be regarded as a small step in an overall shift, in which society begins to view those with addictions in a more positive light.

The social construction model created by Schneider & Ingram (1993) can be used as a tool to help understand why certain demographics are treated the way they are by society as a whole. Applying it to people with disabilities is an excellent way to conceptualize their perception in the eyes of the public. Orienting policy decisions primarily using this framework will help to create a culture of acceptance for people with addictions, and can result in a shift of their categorization from deviants to dependants (Brucker, 2009). This shift will further assist in allowing for easier access to services as well as contribute to the developing view of people with addictions as people who need to be helped, not punished (Goodwin & Sias, 2014; Flacks, 2012).

The argument for allowing addiction to be considered a disability can be examined using the social model as well. In this model, disability is viewed as resulting from societal barriers (Oliver, 2013). The exclusion of addiction from disability legislation could be thought of as one of these barriers, preventing people with addictions from accessing services which would assist them in becoming functioning members of society. Inclusion of addiction within disability legislation would also have a



profound impact on the way society thinks of people with addictions, and would help to move them across the spectrum of social construction from the category of deviants to the category of dependants (Flacks, 2012).

Although the social model of disability can be extremely helpful in making society more accessible, it is not an all-encompassing solution. The problem of a disabling society is quite complex. Scholars note that one of the social model's particularly weak points is that it leads to grouping all people with disabilities into one category (Owens, 2015; Samaha, 2007). This could become problematic, as it is clear that any such "group" is necessarily heterogeneous. This heterogeneous group is by definition necessarily diverse, with each individual having specific needs and requiring specific accommodations. The social model of disability can also be critiqued for its unintentional creation of a hierarchy of disabilities, where some are deemed more worthy of receiving attention (and funding) than others (Samaha, 2007). Applying social construction theory to this hierarchy of disabilities would likely result in a similar placement of addictions very low on the list (Brucker, 2009).

Addressing the many concerns with the social model of disability, Oliver (2013) ultimately states that although it is recognized there are problems with its application, there has been no other model created which could adequately replace it. Looking to the future, this seems to be the most prominent gap in the literature. Arguments can be made against the social model of disability, but until an adequate replacement is presented, this model is doing more help than harm for people with disabilities – addictions included.

## Conclusions

By examining the social construction theory, it can be seen clearly that society is more welcoming to individuals who are identified as a part of the dependent category than those who are viewed as deviants (Schneider & Ingram, 1993). The social model of disability contributes to our understanding of the way the identities of people with addictions are socially constructed. It is evident that once people with addictions are viewed in a more positive light, more opportunities will arise for them to overcome societal barriers. A blatant barrier to the success of individuals with addictions is stigmatization, a result of the view of addiction as deviance

(Brucker, 2009). One way in which this barrier can be removed is through policy reform: including addictions in disability legislation will help facilitate a shift in the identification of addiction with being deviant to being dependent in character (Flacks, 2012; Goodwin & Sias, 2014).

Contemporary disability studies are beginning to view disability as a complex, multi-dimensional state. Focussing on individual experiences begins to fill in gaps of understanding which the social model of disability cannot quite address (Martiny, 2015). Therefore, further studies focusing on individual experiences of addiction under a variety of policies would be welcome. The majority of the literature reviewed above looks at people with addictions as a group (Brucker, 2009; Flacks, 2012; Goodwin & Sias, 2014); however, new pieces focusing on the functioning of the phenomenology of addictions could significantly enhance public understanding of addictions and the role in which disability legislation can play in their mitigation.

[ | ]

## References

- Brucker, D. L. (2009). Social construction of disability and substance abuse within public disability benefit systems. *International Journal of Drug Policy*, 20, 418-423. doi: 10.1016/j.drugpo.2008.09.008
- Flacks, Simon. (2012). Deviant disabilities: the exclusion of drug and alcohol addiction from the equality act of 2010. *Social & Legal Studies*, 21(3), 395-412. doi: 10.1177/0964663912437991
- Goodwin, L. R., & Sias, S. M. (2014). Severe substance use disorder viewed as a chronic condition and disability. *Journal of Rehabilitation*, 80(4), 42-49.
- Government of Ontario. (2005). *Accessibility for Ontarians with Disabilities Act*. Retrieved from Government of Ontario: [www.ontario.ca/laws/statute/05a11](http://www.ontario.ca/laws/statute/05a11)
- Larkin, M., & Griffiths, M. D. (2004). Dangerous sports and recreational drug use: rationalizing and contextualizing risk. *Journal of Community and Applied Psychology*, 14(4), 215-232. doi: 10.1002/casp.770

- Martiny, K. M. (2015). How to develop a phenomenological model of disability. *Medical Health Care and Philosophy*, 18(1), 553-565. doi:10.1007/s11019-015-9625-x
- Oliver, M. (2013). The social model of disability: thirty years on. *Disability and Society*, 28(7), 1024-1026. doi:10.1080/09687599.2013.818773
- Owens, S. (2015). Exploring the critiques of the social model of disability: the transformative possibility of Arendt's notion of power. *Sociology of Health & Illness*, 37(3), 385-403. doi:10.1111/1467-9566.12199
- Samaha, A. M. (2007). What good is the social model of disability? *University of Chicago Law Review*, 74(4), 1251-1308. doi:10.2307/20141862
- Schneider, A., & Ingram, H. (1993). Social construction of target populations: implications for politics and policy. *American Political Science Review*, 87(2), 334-347. doi: 10.4337/9781783472352.00022
- Seear, K. & Fraser, S. (2014). Beyond criminal law: The multiple constitution of addiction in Australian legislation. *Addiction Research & Theory*, 22(5), 438-450. doi: 10.3109/16066359.2014.910511
- Wasserman, David. (2004). Addiction and disability: moral and policy issues. *Substance Use & Misuse*, 39(3), 461-488. doi: 10.1081/JA-120029986
- Wayne Marsden v Coffs Harbour and District Ex-Servicemen & Women's Memorial Club Ltd, H98/51 (The Human Rights and Equal Opportunity Commission 1999). <https://www.humanrights.gov.au/wayne-marsden-v-coffs-harbour-and-district-ex-servicemen-womens-memorial-club-ltd>